

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 3.14 FilmG224 1-3-58 et
13171
CERTIFICATE OF DEATH

13169

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY Hartford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY Hartford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hartford-Grace		c. LENGTH OF STAY IN 1b 2 hrs 15 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hartford Memorial Hospital				d. STREET ADDRESS 328 Law St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Hubert Last Alder R.				4. DATE OF DEATH Month 12 Day 18 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 March 1903		9. AGE (In years lost birthday) 54 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY Dentist		11. BIRTHPLACE (State or foreign country) Switzerland		12. CITIZEN OF WHAT COUNTRY? Switzerland	
13. FATHER'S NAME Charles Alder				14. MOTHER'S MAIDEN NAME Louise Kunz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213 38 9111		17. INFORMANT Address Mina Alder (wife, 328 Law St. 16d, Md.)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 Hepatorenal syndrome DUE TO Post-hepatic cirrhosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 48 hr. 3 1/2 mo.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-20-1957 to 12-18-1957 that I last saw the deceased alive on 12-17-1957 and that death occurred at 9:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8 Law St. Aberdeen, Md. DATE SIGNED							
ACTUAL SIGNATURE Peter P. Rodman M.D.							
PHYSICIAN'S NAME (Type) Peter P. Rodman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/21/1957		22c. NAME OF CEMETERY OR CREMATORY Greenwood		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John E. Carving Aberdeen and				24a. REC'D BY REGISTRAR DATE Dec 22/57		24b. REGISTRAR'S SIGNATURE Mellie R. Perry	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. PLACE OF DEATH</p>		<p>9. TIME OF DEATH</p>		<p>10. SIGNATURE OF DECEASED</p>		<p>11. SIGNATURE OF WITNESSES</p>		<p>12. SIGNATURE OF REGISTRAR</p>		<p>13. SIGNATURE OF MINISTER OF RELIGION</p>		<p>14. SIGNATURE OF CHURCH CLERK</p>		<p>15. SIGNATURE OF BURIAL CLERK</p>		<p>16. SIGNATURE OF BURIAL OFFICER</p>		<p>17. SIGNATURE OF BURIAL OFFICER</p>		<p>18. SIGNATURE OF BURIAL OFFICER</p>		<p>19. SIGNATURE OF BURIAL OFFICER</p>		<p>20. SIGNATURE OF BURIAL OFFICER</p>		<p>21. SIGNATURE OF BURIAL OFFICER</p>		<p>22. SIGNATURE OF BURIAL OFFICER</p>		<p>23. SIGNATURE OF BURIAL OFFICER</p>		<p>24. SIGNATURE OF BURIAL OFFICER</p>		<p>25. SIGNATURE OF BURIAL OFFICER</p>		<p>26. SIGNATURE OF BURIAL OFFICER</p>		<p>27. SIGNATURE OF BURIAL OFFICER</p>		<p>28. SIGNATURE OF BURIAL OFFICER</p>		<p>29. SIGNATURE OF BURIAL OFFICER</p>		<p>30. SIGNATURE OF BURIAL OFFICER</p>		<p>31. SIGNATURE OF BURIAL OFFICER</p>		<p>32. SIGNATURE OF BURIAL OFFICER</p>		<p>33. SIGNATURE OF BURIAL OFFICER</p>		<p>34. SIGNATURE OF BURIAL OFFICER</p>		<p>35. SIGNATURE OF BURIAL OFFICER</p>		<p>36. SIGNATURE OF BURIAL OFFICER</p>		<p>37. SIGNATURE OF BURIAL OFFICER</p>		<p>38. SIGNATURE OF BURIAL OFFICER</p>		<p>39. SIGNATURE OF BURIAL OFFICER</p>		<p>40. SIGNATURE OF BURIAL OFFICER</p>		<p>41. SIGNATURE OF BURIAL OFFICER</p>		<p>42. SIGNATURE OF BURIAL OFFICER</p>		<p>43. SIGNATURE OF BURIAL OFFICER</p>		<p>44. SIGNATURE OF BURIAL OFFICER</p>		<p>45. SIGNATURE OF BURIAL OFFICER</p>		<p>46. SIGNATURE OF BURIAL OFFICER</p>		<p>47. SIGNATURE OF BURIAL OFFICER</p>		<p>48. SIGNATURE OF BURIAL OFFICER</p>		<p>49. SIGNATURE OF BURIAL OFFICER</p>		<p>50. SIGNATURE OF BURIAL OFFICER</p>		<p>51. SIGNATURE OF BURIAL OFFICER</p>		<p>52. SIGNATURE OF BURIAL OFFICER</p>		<p>53. SIGNATURE OF BURIAL OFFICER</p>		<p>54. SIGNATURE OF BURIAL OFFICER</p>		<p>55. SIGNATURE OF BURIAL OFFICER</p>		<p>56. SIGNATURE OF BURIAL OFFICER</p>		<p>57. SIGNATURE OF BURIAL OFFICER</p>		<p>58. SIGNATURE OF BURIAL OFFICER</p>		<p>59. SIGNATURE OF BURIAL OFFICER</p>		<p>60. SIGNATURE OF BURIAL OFFICER</p>		<p>61. SIGNATURE OF BURIAL OFFICER</p>		<p>62. SIGNATURE OF BURIAL OFFICER</p>		<p>63. SIGNATURE OF BURIAL OFFICER</p>		<p>64. SIGNATURE OF BURIAL OFFICER</p>		<p>65. SIGNATURE OF BURIAL OFFICER</p>		<p>66. SIGNATURE OF BURIAL OFFICER</p>		<p>67. SIGNATURE OF BURIAL OFFICER</p>		<p>68. SIGNATURE OF BURIAL OFFICER</p>		<p>69. SIGNATURE OF BURIAL OFFICER</p>		<p>70. SIGNATURE OF BURIAL OFFICER</p>		<p>71. SIGNATURE OF BURIAL OFFICER</p>		<p>72. SIGNATURE OF BURIAL OFFICER</p>		<p>73. SIGNATURE OF BURIAL OFFICER</p>		<p>74. SIGNATURE OF BURIAL OFFICER</p>		<p>75. SIGNATURE OF BURIAL OFFICER</p>		<p>76. SIGNATURE OF BURIAL OFFICER</p>		<p>77. SIGNATURE OF BURIAL OFFICER</p>		<p>78. SIGNATURE OF BURIAL OFFICER</p>		<p>79. SIGNATURE OF BURIAL OFFICER</p>		<p>80. SIGNATURE OF BURIAL OFFICER</p>		<p>81. SIGNATURE OF BURIAL OFFICER</p>		<p>82. SIGNATURE OF BURIAL OFFICER</p>		<p>83. SIGNATURE OF BURIAL OFFICER</p>		<p>84. SIGNATURE OF BURIAL OFFICER</p>		<p>85. SIGNATURE OF BURIAL OFFICER</p>		<p>86. SIGNATURE OF BURIAL OFFICER</p>		<p>87. SIGNATURE OF BURIAL OFFICER</p>		<p>88. SIGNATURE OF BURIAL OFFICER</p>		<p>89. SIGNATURE OF BURIAL OFFICER</p>		<p>90. SIGNATURE OF BURIAL OFFICER</p>		<p>91. SIGNATURE OF BURIAL OFFICER</p>		<p>92. SIGNATURE OF BURIAL OFFICER</p>		<p>93. SIGNATURE OF BURIAL OFFICER</p>		<p>94. SIGNATURE OF BURIAL OFFICER</p>		<p>95. SIGNATURE OF BURIAL OFFICER</p>		<p>96. SIGNATURE OF BURIAL OFFICER</p>		<p>97. SIGNATURE OF BURIAL OFFICER</p>		<p>98. SIGNATURE OF BURIAL OFFICER</p>		<p>99. SIGNATURE OF BURIAL OFFICER</p>		<p>100. SIGNATURE OF BURIAL OFFICER</p>	
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RECEIVED
 DEC 26 1957
 BUREAU V. 2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13172 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13170/85

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hovre de Grace</u>	c. LENGTH OF STAY IN 1b -	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bridgeport</u> 75X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>RDI</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ANN</u> Middle <u>Allen</u> Last <u>Allen</u>		4. DATE OF DEATH Month <u>December</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 3, 1913</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>NESTER</u>	
14. MOTHER'S MAIDEN NAME <u>NO INFORMATION</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>No.</u>		17. INFORMANT Address <u>CONSHOHOCKEN PA.</u> <u>Mrs BARBARA HENSLEY</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CRUSHING INJURY OF HEAD.</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto-bus type</u>		20c. TIME OF INJURY Month, Day, Year <u>12-22-57</u> Hour <u>8</u> p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US Route 40 Perryville Cecil Md</u>	
20f. (City or town) <u>Perryville Cecil Md</u>		20g. (County) <u>Cecil Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u> DATE SIGNED <u>12-22-57</u>	
EXAMINER'S NAME (Type) <u>Gerald C. Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC 28, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>VALLEY FORGE MEMORIAL PARK/UPPER MERION TWP. PA.</u>		22d. LOCATION (City, town, or county) (State) <u>PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pepper Funeral Home Donald H. Pepper, Inc.</u>		24a. REC'D BY REGISTRAR <u>DEC 30 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Dr. L. Lewis</u>			

Handwritten: $2H \rightarrow H_2$

14/11/2014

BUREAU V. 5

REC 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13200

CERTIFICATE OF DEATH

Reg. Dist. No.

13171

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>				c. LENGTH OF STAY IN 1b <u>Entire life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>H</u> Last <u>Amoss</u>				4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept-30-1905</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Samuel H. Amoss</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
14. MOTHER'S MAIDEN NAME <u>Bora Benson</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>278-14-2030</u>		17. INFORMANT Address <u>Mrs. Rose Amoss Fallston Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u>Coronary Artery Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 7</u> , 19 <u>38</u> , to <u>December 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 16</u> , 19 <u>55</u> , and that death occurred at <u>9:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Maryland</u>				DATE SIGNED <u>December 9, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>				<u>no</u> Deputy Medical Examiner <u>Harford County</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 11, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Fallston, Hfd. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Archer</u>				ADDRESS <u>Benson Md</u>		24a. REC'D BY REGISTRAR <u>Trissella</u>	
				24b. REGISTRAR'S SIGNATURE <u>Trissella</u>		DATE <u>12 12 1957</u>	

CERTIFICATE OF DEATH

1-1-1967

PLACE OF DEATH		DATE OF DEATH	
HOSPITAL		12-12-1967	
NAME OF DECEASED		AGE	
JOHN J. MILLAND		68	
SEX		MALE	
RACE		WHITE	
EDUCATION		HIGH SCHOOL	
OCCUPATION		RETIRED	
MARITAL STATUS		MARRIED	
DATE OF MARRIAGE		1915	
PLACE OF BIRTH		NEW YORK	
DATE OF BIRTH		1899	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		DATE	
J. J. MILLAND		12-12-1967	
SIGNATURE OF REGISTRAR		DATE	
J. J. MILLAND		12-12-1967	

BUREAU V. S.

DEC 12 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13172

13173

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>46 Smith Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Madora</i> Last <i>Becker</i>		4. DATE OF DEATH Month <i>12</i> Day <i>19</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 23 - 1881</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR: Months <i>7</i> Days <i>19</i> Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Stroughan</i>		14. MOTHER'S MAIDEN NAME <i>Lauria Robbins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs Glen Bagwell</i>		Address <i>46 Smith St Aberdeen Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Haemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Thrombocytopenia</i> DUE TO (c) <i>Acute myelogenous leukaemia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 hr.</i> <i>6 wk</i> <i>6 wk</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12-19-57</i> to <i>12-19-57</i> , that I last saw the deceased alive on <i>12-19-57</i> , and that death occurred at <i>8:00 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Peter P. Rodman</i> M.D.		<i>8 Law St. Aberdeen, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Peter P. Rodman, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/22/1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Babers Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Aberdeen Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Carrying Aberdeen Md</i> ADDRESS		24a. REC'D BY REGISTRAR <i>12-22-57</i> 24b. REGISTRAR'S SIGNATURE <i>Thelie R. Perry</i>	

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BALTIMORE, MD.
 CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
MARRIAGE		SINGLE		MARRIED		WIDOWED		DIVORCED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE	
MARRIED		SINGLE		MARRIED		WIDOWED		DIVORCED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
SHOOTING		SUICIDE		MEMPHIS, TENN.		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
DETAILS OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
SHOOTING		SUICIDE		MEMPHIS, TENN.		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
DETAILS OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
SHOOTING		SUICIDE		MEMPHIS, TENN.		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13174 CERTIFICATE OF DEATH

13173

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABERDEEN</u>				c. LENGTH OF STAY IN 1b <u>18 HRS.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABERDEEN 31</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>43 HANOVER ST.</u>			
d. STREET ADDRESS <u>43 HANOVER ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>L.</u> Last <u>Boddy</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/13/57</u>	
9. AGE (In years lost birthday) yrs. <u>18</u>		IF UNDER 1 YEAR Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Preston Boddy</u>		14. MOTHER'S MAIDEN NAME <u>LILLIE REED</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Lillie Boddy - Aberdeen, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>762.0</u> DUE TO (c) <u>762.0</u> DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DECEMBER 13 1957</u> to <u>DECEMBER 14 1957</u> , that I last saw the deceased alive on <u>DECEMBER 13 1957</u> , and that death occurred at <u>4:50 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George T. Stansbury</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>569 Revolution St. Harve de Grace, Md. 12/14/57</u>			
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				HARVE DE GRACE, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Attilio B. Bullock</u>				ADDRESS <u>Harve de Grace, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>12-15-57</u>	
24b. REGISTRAR'S SIGNATURE <u>A. H. Kemmell</u>							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF WITNESS</p>		<p>15. SIGNATURE OF PHYSICIAN</p>		<p>16. SIGNATURE OF CORONER</p>	
<p>17. SIGNATURE OF JUDGE</p>		<p>18. SIGNATURE OF CLERK</p>		<p>19. SIGNATURE OF NOTARY</p>		<p>20. SIGNATURE OF SHERIFF</p>	
<p>21. SIGNATURE OF DEPUTY SHERIFF</p>		<p>22. SIGNATURE OF JURY</p>		<p>23. SIGNATURE OF GRAND JURY</p>		<p>24. SIGNATURE OF DISTRICT COURT</p>	
<p>25. SIGNATURE OF CIRCUIT COURT</p>		<p>26. SIGNATURE OF APPELLATE COURT</p>		<p>27. SIGNATURE OF SUPREME COURT</p>		<p>28. SIGNATURE OF U.S. DISTRICT COURT</p>	
<p>29. SIGNATURE OF U.S. COURT OF APPEALS</p>		<p>30. SIGNATURE OF U.S. SUPREME COURT</p>		<p>31. SIGNATURE OF STATE DEPARTMENT OF HEALTH</p>		<p>32. SIGNATURE OF BALTIMORE HEALTH DEPARTMENT</p>	

BUREAU V. S.

DEC 18 1957

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13175

CERTIFICATE OF DEATH

13174

Reg. Dist. No. 185-

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>		c. LENGTH OF STAY IN 1b <u>6 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 BELAIR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				d. STREET ADDRESS <u>1 RD #1 BOX 351</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EUGENE</u> Middle <u>H</u> Last <u>BOONE</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-8-1888</u>	
9. AGE (In years lost birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jacob Boone</u>				14. MOTHER'S MAIDEN NAME <u>Leannah Conway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1911</u>		17. INFORMANT <u>Mrs. Martha M. Boone - Bel-Air, Md.</u>		Address <u>Rt. 1, Box 357</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Insufficiency</u> DUE TO (c) <u>Hypertensive-Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Dec. 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 21</u> , 19 <u>57</u> , and that death occurred at <u>5:20</u> M, from the causes and on the date stated above. A ADDRESS (Street, city or town, state) <u>529 Revolution St., Harford County, Md.</u> DATE SIGNED <u>12/21/57</u> ACTUAL SIGNATURE <u>George T. Stansbury, M.D.</u> PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u> <u>Harford County, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clark's Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Harford County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Bullenck - Harford County, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>12-23-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13175
187

13176

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Churchville</u>			
3. NAME OF DECEASED (Type or print) <u>Oscar</u> First <u>Bowser</u> Middle <u>Bowser</u> Last				4. DATE OF DEATH Month <u>Dec.</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1882</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Bowser</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Edith Bowser</u>		Address <u>Bel Air R.D. #2 Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (a), stating the <u>underlying</u> cause lost. (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> (c) <u>Hypertensive Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>12/20</u> , 19 <u>54</u> , to <u>12/25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/23</u> , 19 <u>57</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George J. Stansbury</u>				ADDRESS (Street, city or town, state) <u>569 Revolution St., Havre de Grace, Md.</u>			
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				DATE SIGNED <u>12/27/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 28, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hosanna</u>		22d. LOCATION (City, town, or county) (State) <u>Darlington, Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. Williams</u>				ADDRESS <u>Abingdon, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 31 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Priscilla Howard</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

DEC 31 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13177

CERTIFICATE OF DEATH

13176

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural #1 (Stephens)</u>		d. STREET ADDRESS <u>Rural #1 (Stephens)</u>	
3. NAME OF DECEASED (Type or print) First <u>Hoyt</u> Middle <u>Brown</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/29/1955</u>
9. AGE (In years last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Maile Osborne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Morgan Reid Aberdeen #1 Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>491X</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 19</u> , 19 <u>57</u> , to <u>Dec. 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 17</u> , 19 <u>57</u> , and that death occurred at <u>6:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) <u>569 Revolution St., Haver de Grace, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		DATE SIGNED <u>12/21/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/23/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barrington Aberdeen Rd.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Nellie R. Perry</u>	
DATE <u>Dec 23/57</u>			

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Registrar		11. Signature of Physician		12. Signature of Coroner		13. Signature of Medical Examiner		14. Signature of Pathologist		15. Signature of Forensic Pathologist		16. Signature of Toxicologist		17. Signature of Bacteriologist		18. Signature of Chemist		19. Signature of Radiologist		20. Signature of Other Specialist	

BUREAU A. H.

DEC 27 1957

RECEIVED

13201 CERTIFICATE OF DEATH

13177

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Chesapeake Gardens Aberdeen, Md.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital			d. STREET ADDRESS 402-E Watervaliet St		
3. NAME OF DECEASED (Type or print) First RICHARD Middle BURKE Last BURKE			4. DATE OF DEATH Month December Day 2 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 September 53		9. AGE (In years last birthday) 4 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Frankfurt Germany	
13. FATHER'S NAME Lester Burke			14. MOTHER'S MAIDEN NAME Joan I Harris		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT Father	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Concussion Severe 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 hours
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) head injury, Laceration spleen, Contusion of left Lung		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in automobile, struck by truck			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 0955 AM 2 Dec 1957	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway Route 40		20f. (City or town) Aberdeen	(County) Harford (State) Md.

21. I certify that I attended the deceased from 2 December, 1957 , to 2 December, 1957 , that I last saw the deceased alive on 2 December, 1957 , and that death occurred at 1840p M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) V. G. Coseriu Major MC	DATE SIGNED 3 December 1957
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ACTUAL SIGNATURE V. G. Coseriu Major MC		PHYSICIAN'S NAME (Type) V. G. COSERIU MAJOR MC	
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/6/57	22c. NAME OF CEMETERY OR CREMATORY Post Cemetery	22d. LOCATION (City, town, or county) (State) Aberdeen Proving Ground, Md.
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23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring	ADDRESS Aberdeen, Md.	24a. REC'D BY REGISTRAR Dec 6/57	24b. REGISTRAR'S SIGNATURE Thelma R. Perry
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

For Use in

Name of Deceased		Sex		Age		Date of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Occupation		Residence		Signature of Registrar		Signature of Physician	
John Doe		Male		45		1910-01-01		1957-12-01		Boston, Mass.		Heart Disease		Natural		Teacher		123 Main St.		John Doe		John Doe	

BUREAU V. S.

DEC 9 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

151

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harper-de-Grace</u>				c. LENGTH OF STAY IN 1b <u>11 days</u> x2 <u>Aberdeen.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>RT.# 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Melvin</u> Middle <u>Thomas</u> Last <u>Burkins</u>				4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3 Sept. 1900</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck driver Oil Company</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-07-7311</u>		17. INFORMANT <u>Elsie Burkins #1 Aberdeen Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio Vascular disease</u> DUE TO (c) <u>5 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov 15</u> , 19 <u>57</u> , to <u>12/2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 2</u> , 19 <u>57</u> , and that death occurred at <u>4P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dudley Phillips</u>				ADDRESS (Street, city or town, state) <u>Darlington Md</u>		DATE SIGNED <u>12/4/57</u>	
PHYSICIAN'S NAME (Type) <u>Dudley Phillips</u>				Darlington, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gar.</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Fanning</u>				ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR <u>Dec 6/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mellie R Perry</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13202 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13179

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norrisville</u> c. LENGTH OF STAY IN 1b <u>-</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Church Road, Highway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norrisville x 2</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Gladys H. Clark</u> First Middle Last 4. DATE OF DEATH <u>December 14</u> 19 <u>57</u> Month Day Year				5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 1, 1920</u> 9. AGE (In years last birthday) <u>37</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>NORRISVILLE E</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HOWARD PRESTON HULSHART</u>				14. MOTHER'S MAIDEN NAME <u>OLIVE E WAILES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>217-16-668</u>		17. INFORMANT <u>Thomas A Clarke</u> Address <u>110 LIRKSH AVE BALTO. 6 MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound, comminuted</u> <u>816X</u> DUE TO <u>fracture skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>fracture skull</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto-object type</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>4</u> <u>12-14</u> 19 <u>57</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Church Road</u>		20f. (City or town) <u>Norrisville</u> (County) <u>Hartford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md</u> DATE SIGNED <u>12-15-57</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NORRISVILLE</u>		22d. LOCATION (City, town, or county) <u>NORRISVILLE</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Furtz</u> ADDRESS <u>Garrettsville Md</u>				24a. REC'D BY REGISTRAR <u>12-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>Burilla Howard</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
PREVIOUS ILLNESS		TREATMENT		HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATION		POST-MORTEM EXAMINATION	
FAMILY HISTORY		SOCIAL HISTORY		PSYCHOLOGICAL HISTORY		PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS		GROSS FINDINGS	
SIGNATURE OF EXAMINER		TITLE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		HOSPITAL NO.		CASE NO.	

BUREAU V. 2

DEC. 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13180

CERTIFICATE OF DEATH

Reg. Dist. No.

13180

185

1. PLACE OF DEATH a. COUNTY <i>Harford Maryland</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Chase</i>		c. LENGTH OF STAY IN 1b <i>40 yrs.</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Chase</i> 24		d. STREET ADDRESS <i>216 N. Union Ave.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Anne</i> Middle <i>E.</i> Last <i>Davis</i>		4. DATE OF DEATH Month <i>12</i> Day <i>16</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 12, 1888</i>
9. AGE (In years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Dublin Harford Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm. S. Daugherty</i>		14. MOTHER'S MAIDEN NAME <i>Thereseanna Cantler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Mrs. F. C. Kohler</i>		Address <i>216 N. Union Ave. Harford Chase, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pulmonary Infarction</i> DUE TO (c) <i>Coronary Thrombosis Embolism</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>3 days</i> <i>10 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12/13</i> , 19 <i>57</i> , to <i>12/16</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>12/16</i> , 19 <i>57</i> , and that death occurred at <i>10:10</i> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank Wolbert M.D.</i>		ADDRESS (Street, city or town, state) <i>209 North Union Ave. Harford Chase, Md.</i>	
PHYSICIAN'S NAME (Type) <i>FRANK WOLBERT M.D.</i>		DATE SIGNED <i>12/18/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/19/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Harford Chase, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Wm. Harford Chase, Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>12-19-57</i>		24b. REGISTRAR'S SIGNATURE <i>G. L. Harris M.D.</i>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF FUNERAL HOME		16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF MENTAL HEALTH PROFESSIONAL		18. SIGNATURE OF OTHER		19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER		22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER		25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER		31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER		37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER		43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER		46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER		49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER		61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER		73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER		76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER		85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER		91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER		97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	
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BUREAU V. S.

DEC 23 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13181

CERTIFICATE OF DEATH

Reg. Dist. No.

13181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER de Grace, Rt #1</u>		c. LENGTH OF STAY IN 1b <u>23 hrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER de Grace Rt #1-x0</u>		d. STREET ADDRESS <u>Artin Hood Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gordon</u> Middle <u>L</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/24/1931</u>
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months <u>25</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Millard Davis</u>		14. MOTHER'S MAIDEN NAME <u>Martha (Roark)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Millard Davis</u>		Address <u>Artin Hood Road, Harford Co. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Nephritis</u> DUE TO (c) <u>3 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 10</u> , 19 <u>57</u> , to <u>Dec. 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 25</u> , 19 <u>57</u> , and that death occurred at <u>12:15</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gunter D. Hirsch</u>		ADDRESS (Street, city or town, state) <u>421 Congress Ave. Haver de Grace, Md.</u>	
DATE SIGNED <u>12-26-57</u>		DATE SIGNED <u>12-26-57</u>	
PHYSICIAN'S NAME (Type) <u>GUNTER D. HIRSCH</u>		ADDRESS <u>HAVER de Grace Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/28/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stephen Perry Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Haver de Grace Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Quinn R. Smith</u>		ADDRESS <u>12-26-57</u>	
24a. REC'D BY REGISTRAR <u>G. R. Lewis</u>		24b. REGISTRAR'S SIGNATURE <u>G. R. Lewis</u>	

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

DEC 30 1957

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13203 CERTIFICATE OF DEATH

Reg. Dist. No.

187

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Bel Air</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural X2 Bel Air</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 Druswell Calvary</u>			
3. NAME OF DECEASED (Type or print) <u>Karren Fay Epperson</u> First Middle Last				4. DATE OF DEATH <u>December 8 1957</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 28, 1957</u>		9. AGE (In years last birthday) <u>7mo</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert L. Epperson</u>				14. MOTHER'S MAIDEN NAME <u>Mollie M. Bailey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Albert L. Epperson</u> Address <u>New Castle Delaware</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> <u>490x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>10 am. 12-8-57</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-7</u> , 19 <u>57</u> to <u>12-8</u> , 19 <u>57</u> that I last saw the deceased alive on <u>12-7</u> , 19 <u>57</u> , and that death occurred at <u>10A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				ADDRESS (Street, city or town, state) <u>Bel Air, Md.</u> DATE SIGNED <u>12-8-57</u>			
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 11, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Epperson Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bluefield, Tazewell, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McConaughy</u> ADDRESS <u>Abingdon, Maryland.</u>				24a. REC'D BY REGISTRAR <u>REC 12 1957</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Theresa J. Forward</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES EARL RAY		M		35		W		1922		MEMPHIS, TENN.		APRIL 4, 1968		MEMPHIS, TENN.		SHOOTING		HOMICIDE		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. SOCIAL SECURITY NUMBER		18. PREVIOUS RECORD		19. PREVIOUS RECORD		20. PREVIOUS RECORD		21. PREVIOUS RECORD		22. PREVIOUS RECORD		23. PREVIOUS RECORD		24. PREVIOUS RECORD	
MEMBER OF CONGRESS		HIGH SCHOOL		METHODIST		MARRIED		000-000000		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF REGISTRAR		26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED		28. SIGNATURE OF DECEASED		29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED		31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

DEC 12 1957

RECEIVED

13204 CERTIFICATE OF DEATH

13183

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fallston</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X1 Fallston</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Friendship Rd.</i>		d. STREET ADDRESS <i>Friendship Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Maurice</i> Middle <i>C.</i> Last <i>Fitch</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>30</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec, 17, 1890</i>
9. AGE (In years last birthday) <i>67</i> yrs.		IF UNDER 1 YEAR: Months <i>67</i> Days <i>67</i> Hours <i>67</i> Min. <i>67</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dispatcher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Sand & Gravel Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto. Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Robert Fitch</i>		14. MOTHER'S MAIDEN NAME <i>Susan Grammer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-28-4034</i>	
17. INFORMANT <i>Mrs. Helen P. Fitch</i>		Address <i>Friendship Rd. Fallston Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>430.1</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Coronary Sclerotic Heart Dis</i> DUE TO (b) <i>10 yrs.</i> DUE TO (c) <i>30 min.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>30 min.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bronchial Asthma, Ch. Alcoholism</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>1957</i> Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/17</i> to <i>12/30</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>12/30</i> , 19 <i>57</i> , and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Clifford F. Hudson</i>		ADDRESS (Street, city or town, state) <i>Fork Md.</i>	
PHYSICIAN'S NAME (Type) <i>CLIFFORD F. HUDSON</i>		DATE SIGNED <i>FORK, MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 2, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Zion Evan. Lutheran</i>		22d. LOCATION (City, town, or county) (State) <i>Stemmers Run Balto. Co., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lillian Funeral Home</i>		ADDRESS <i>7401 Belair Rd.</i>	
24a. REC'D BY REGISTRAR <i>JAN 3 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Priscilla Howard</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13205

CERTIFICATE OF DEATH

13184

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #1				d. STREET ADDRESS R.D. #1			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lena Middle Matilda Last Ford				4. DATE OF DEATH Month December Day 6 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 27 Sept. 1895	
9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR Months 62 Days 6 Hours 1957		IF UNDER 24 HRS. Months 62 Days 6 Hours 1957			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Perryman, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George S. Ford				14. MOTHER'S MAIDEN NAME Sarah Matilda Day			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ** **		17. INFORMANT Address E. Lawrence Ford Perryman, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Marasmus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Reticular cell sarcoma, retroperitoneal DUE TO (c) 200.0						INTERVAL BETWEEN ONSET AND DEATH 3 wk 2 1/2 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June , 19 55 , to 12-6- , 19 57 , that I last saw the deceased alive on Dec 5-7 , 19 57 , and that death occurred at 6:50 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8 Law Street DATE SIGNED Dec 7-57							
ACTUAL SIGNATURE Peter P. Rodman M.D.				DATE SIGNED Dec 7-57			
PHYSICIAN'S NAME (Type) Peter P. Rodman M.D.				ADDRESS Aberdeen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/8/57		22c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery		22d. LOCATION (City, town, or county) (State) Perryman, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John S. Leasing				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR Dec 7-57	
				24b. REGISTRAR'S SIGNATURE Mellie R. Perry			

MISSOURI STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Color		Marital Status		Occupation	
George S. Ford		Male		35		Jan 15 1902		St. Louis, Mo.		White		Single		None	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death		Date of Death		Time of Death		Signature of Physician	
Pneumonia		Pneumonia		Pneumonia		Accident		St. Louis, Mo.		Jan 15 1937		10:00 AM		J. H. Smith, M.D.	
Signature of Registrar		Signature of Physician		Signature of Coroner		Signature of Burial Officer		Signature of Undertaker		Signature of Witness		Signature of Witness		Signature of Witness	
J. H. Smith, Registrar		J. H. Smith, M.D.		J. H. Smith, Coroner		J. H. Smith, Burial Officer		J. H. Smith, Undertaker		J. H. Smith, Witness		J. H. Smith, Witness		J. H. Smith, Witness	

BUREAU V. S.

DEC 10 1937

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13206 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13185

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street	c. LENGTH OF STAY IN 1b 2 mo.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home		d. STREET ADDRESS 1	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First George F. Middle Frank Last 		4. DATE OF DEATH Month December Day 17 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 28, 1957
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months 2 Days Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Maryland	11. BIRTHPLACE (State or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Robert Tenaglia	
14. MOTHER'S MAIDEN NAME Sally Franke		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 		17. INFORMANT Address Mrs. Louise Lindberg, 1107 Cavendish Way	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald C Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Airm Md. DATE SIGNED Dec. 16 1957	
EXAMINER'S NAME (Type) Gerald C Palmer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 19, 1957	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Colgate, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.		24a. REC'D BY REGISTRAR DEC 19 1957	
24b. REGISTRAR'S SIGNATURE Priscilla Forwood		EJ	

FOR STATE
HEALTH DEPT.

8800 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

DEC 23 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13182

CERTIFICATE OF DEATH

13186

Reg. Dist. No. 185

1. PLACE OF DEATH o. COUNTY <u>Harford County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Winnie L. (Goines)</u>		4. DATE OF DEATH <u>December 28 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 27/1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>	
13. FATHER'S NAME <u>John Dudley Rudy</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Mc Shady</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Harrison P. Goins</u>		Address <u>Box 378 Harve de Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Posterior Coronary thrombosis with myocardial infarction</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive and arteriosclerotic</u> DUE TO <u>Cardiovascular disease</u> (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2600 Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 9th</u> , 19 <u>57</u> , to <u>Dec 28th</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 28th</u> , 19 <u>57</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Lee</u> M.D.		ADDRESS (Street, city or town, state) <u>211 N. Union Ave.</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u>		DATE SIGNED <u>12/28/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 30/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wagon Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Harford</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>		ADDRESS <u>Bel Air, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jan 3 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. L. L. Lewis</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13207

13187
Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Md b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abert-deen		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun 07X1.2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USA Hosp.				d. STREET ADDRESS RD 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Evelyn Middle Rutter Last Green				4. DATE OF DEATH Month December Day 9 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 Jan 1907		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accounting Clerk		10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George P. Rutter				14. MOTHER'S MAIDEN NAME Margery Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-22-0373		17. INFORMANT Charles H. Green, Rising Sun, Md, RD 1.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH -
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gerald C Palmer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Dec 12-9-57	
EXAMINER'S NAME (Type) Gerald C Palmer - MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12-12-1957		Hopewell Cemetery		Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE W. A. Patterson & Son				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR Dec 11-57	
						24b. REGISTRAR'S SIGNATURE William R. Perry	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5207

NAME OF DECEASED: *John J. Jones*
AGE: *45* SEX: *M*
RESIDENCE: *1234 Main St., Baltimore, Md.*
OCCUPATION: *Engineer*
DATE OF DEATH: *Dec 18, 1957*
PLACE OF DEATH: *Home*
CAUSE OF DEATH: *Heart Disease*
MANNER OF DEATH: *Natural*
SIGNATURE OF EXAMINER: *George L. Jones*
OFFICIAL TITLE: *Medical Examiner*
COUNTY: *Baltimore*
STATE: *Md.*

BUREAU V. 2

DEC 18 1957

RECEIVED

13188

13208

CERTIFICATE OF DEATH

Reg. Dist. No.

102

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kalmia		c. LENGTH OF STAY IN lb 2 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Jarrettsville					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lucretia		First A		Middle Harkins		Last			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1873			
9. AGE (In years last birthday) 84 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Harkins		14. MOTHER'S MAIDEN NAME Sarah Mchen					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Helen Harkins, Bel Air, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Heart Failure, terminating DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cardio-vascular Disease DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 19 55 , to December 20, 19 57 , that I last saw the deceased alive on December 19 , 19 57 , and that death occurred at Forest Hill, Maryland , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED December 20, 19 57									
ACTUAL SIGNATURE Willard P. Hudson		PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 22, 1957		22c. NAME OF CEMETERY OR CREMATORY Brick Baptist Church		22d. LOCATION (City, town, or county) (State) Jarrettsville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hester Bel Air, Md.				24a. REC'D BY REGISTRAR DATE 12-22-57		24b. REGISTRAR'S SIGNATURE Priscilla Lowmyer			

CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Name]</p>		<p>AGE [Age]</p>		<p>SEX [Sex]</p>	
<p>DATE OF DEATH [Date]</p>		<p>TIME OF DEATH [Time]</p>		<p>PLACE OF DEATH [Place]</p>	
<p>CAUSE OF DEATH [Cause]</p>		<p>MANNER OF DEATH [Manner]</p>		<p>REPORTED BY [Name]</p>	
<p>DATE OF REPORT [Date]</p>		<p>TIME OF REPORT [Time]</p>		<p>REPORTED BY [Name]</p>	
<p>DATE OF INTERVIEW [Date]</p>		<p>TIME OF INTERVIEW [Time]</p>		<p>INTERVIEWED BY [Name]</p>	
<p>DATE OF EXAMINATION [Date]</p>		<p>TIME OF EXAMINATION [Time]</p>		<p>EXAMINED BY [Name]</p>	
<p>DATE OF BURIAL [Date]</p>		<p>TIME OF BURIAL [Time]</p>		<p>BURIED BY [Name]</p>	
<p>DATE OF CREMATION [Date]</p>		<p>TIME OF CREMATION [Time]</p>		<p>CREMATED BY [Name]</p>	
<p>DATE OF DISPOSITION [Date]</p>		<p>TIME OF DISPOSITION [Time]</p>		<p>DISPOSED BY [Name]</p>	
<p>DATE OF RETURN [Date]</p>		<p>TIME OF RETURN [Time]</p>		<p>RETURNED BY [Name]</p>	
<p>DATE OF RECEIPT [Date]</p>		<p>TIME OF RECEIPT [Time]</p>		<p>RECEIVED BY [Name]</p>	

BUREAU V. S.

DEC 23 1957

RECEIVED

1

13209 CERTIFICATE OF DEATH

Reg. Dist. No. 182

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

1. PLACE OF DEATH COUNTY <u>HARFORD</u> MARYLAND CITY OR TOWN <u>RURAL JOPPA</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>HARFORD</u> CITY OR TOWN <u>RURAL JOPPA</u> STREET ADDRESS <u>JOPPA RD #2</u>			
3. NAME OF DECEASED (Type or Print) <u>Ozella Marie Heaps</u> (First) (Middle) (Last)				4. DATE OF DEATH <u>12 28 1957</u> (Month) (Day) (Year)			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>1-29-1885</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>HARFORD CO., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>WILLIAM WALSH RICHARDSON</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH RODGERS WILGIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Ruth H. Ziegler Joppa, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Essential Hypertension</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				30 yrs			
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10</u> <u>12-27</u> , 19 <u>57</u> , to <u>12-28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-27</u> , 19 <u>57</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Jed O Hodous</u> M.D.				DATE SIGNED <u>12-28-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-31-1957</u>		NAME OF CEMETERY OR-CREMATORY <u>NORRISVILLE METH.</u>		LOCATION (City, town, or county) (State) <u>NORRISVILLE, HARFORD CO., MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Willa Louwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Churn</u>		ADDRESS <u>Stewartstown Pa</u>	
DATE <u>12-28-57</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13183

CERTIFICATE OF DEATH

Reg. Dist. No.

13190

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belair		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall 03X2.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Conv. Home		d. STREET ADDRESS Box 140 Rt. 1 Joppa, Md.	
3. NAME OF DECEASED (Type or print) First Adam Middle J. Last Heil		4. DATE OF DEATH Month Dec. Day 2, Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1866
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer-Retired		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? US.A.	
13. FATHER'S NAME John Heil		14. MOTHER'S MAIDEN NAME Cecelia Deigelman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. William Plummer		Address Rt. 1 Box 140 Joppa, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION (Embolus incident to Auricular fibrillation) DUE TO (b) Chr. Hypertensive cardio-vascular disease DUE TO (c) ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 6 hrs ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of liver		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 10, 1957, to Dec. 2, 1957, that I last saw the deceased alive on Dec. 1st, 1957, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Willard P. Hudson Forest Hill, Md. 12-2-57 PHYSICIAN'S NAME (Type) WILLARD P. HUDSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-5-1957	
22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lashawn Funeral Home		ADDRESS 7401 Belair Rd	
24a. REC'D BY REGISTRAR DEC 9 1957		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

DEC 9 1957

RECEIVED

13184 CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>#3 Rogers Street</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Stella Blackwell Johnson</i>				4. DATE OF DEATH Month <i>12</i> Day <i>27</i> Year <i>1957</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/24/1878</i>	9. AGE (In years last birthday) <i>79</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Theodore Blackwell</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Thomas</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>E.H. Johnson #3 Rogers St Aberdeen</i>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Renal - Uremia</i> <i>442x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>10/2</i> , 19 <i>44</i> to <i>12-24</i> , 19 <i>57</i> that I last saw the deceased alive on <i>12/24</i> , 19 <i>57</i> , and that death occurred at <i>3:15 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>A. L. Lewis M.D.</i>				ADDRESS (Street, city or town, state) <i>Harford, Md.</i>			
DATE SIGNED <i>Dec 30 - 57</i>				DATE SIGNED <i>Dec 30 - 57</i>			
PHYSICIAN'S NAME (Type)				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>12/30/57</i>		<i>North East Cemetery</i>		<i>North East, Cecil Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James F. Herring Aberdeen Md.</i>				24a. REC'D BY REGISTRAR <i>Dec 30 - 57</i>		24b. REGISTRAR'S SIGNATURE <i>Mellie K Perry</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1911

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

BUREAU V. 1

JAN 2 1911

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13185

CERTIFICATE OF DEATH

13192

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Race St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Nokores</u> Middle <u>Jones</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-1956</u>
9. AGE (In years last birthday) <u>1</u> yrs.		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>18</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Robert H. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Addie E. Griffin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Address <u>Addie E. Jones, Race St, Port Deposit, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>056.1</u> DUE TO <u>Cerebral Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pertussis</u> DUE TO (c) <u>3 weeks</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov-12, 1957</u> to <u>Dec 17, 1957</u> that I last saw the deceased alive on <u>Dec 17-</u> 1957, and that death occurred at <u>8:30 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clarence I. Benson</u> M.D.		ADDRESS (Street, city or town, state) <u>Port Deposit, Md</u> DATE SIGNED <u>12/19/57</u>	
PHYSICIAN'S NAME (Type) <u>Clarence I. Benson, M.D.</u>		<u>Port Deposit Md</u>	
22a. BURIAL, CREMATION, (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-21-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Jones Memorial Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson</u> ADDRESS <u>Perryville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 12-21-57</u>	24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis m.d.</u>

STATE OF CALIFORNIA—DEPARTMENT OF HEALTH—BUREAU OF VITAL STATISTICS

1-8-1965

DEC 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13186

CERTIFICATE OF DEATH

13193

Reg. Dist. No. 182-

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE			
c. LENGTH OF STAY IN 1b LIFETIME				d. STREET ADDRESS 840 OTSEGO ST.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NONE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CLARA HAYES KENNEDY				4. DATE OF DEATH Month Day Year 12 29 1957			
5. SEX 7		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/20/1880	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) HAVRE DE GRACE	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME FRANKLIN OWENS				14. MOTHER'S MAIDEN NAME MARY M. ANDERSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give wpr or dates of service) NO				16. SOCIAL SECURITY NO. UNK		17. INFORMANT Address FRANKLIN KENNEDY, 840 OTSEGO ST.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x Coronary Occlusion DUE TO (b) Chronic Myocarditis DUE TO (c) Chronic Nephritis - Diabetes 260x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 18 19 57 to 12-29 19 57 that I last saw the deceased alive on Dec 29 19 57 , and that death occurred at 7 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Havre de Grace, Md. DATE SIGNED 12/31/57							
ACTUAL SIGNATURE A. L. Lewis				M.D. Havre de Grace, Md.			
PHYSICIAN'S NAME (Type) A. L. Lewis							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/1/58		22c. NAME OF CEMETERY OR CREMATORY ANGEL HILL		22d. LOCATION (City, town, or county) (State) HAVRE DE GRACE MD	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE 12-31-57	
				24b. REGISTRAR'S SIGNATURE A. L. Lewis M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, OCT. 15
CERTIFICATE OF DEATH

RECEIVED
JAN 2 1958
BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13194

13210

CERTIFICATE OF DEATH

Reg. Dist. No. 182

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural Bel Air</u>		<u>32 years</u>		TOWN <u>Rural Bel Air</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wakefield-Forest Drive</u>				STREET ADDRESS (If rural give location) <u>Wakefield-Forest Drive</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Dorothea</u> (Middle) <u>Bilz</u> (Last) <u>Kunkel</u>				(Month) <u>Dec</u> (Day) <u>28</u> (Year) <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>August 22, 1887</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Bilz</u>				14. MOTHER'S MAIDEN NAME <u>Barbara BAIER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Mr. John N. Kunkel Wakefield Forest Drive Bel Air, R.D., Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) <u>CONVULSION & CARDIO RESP FAILURE</u>						<u>5 MINUTES</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CEREBROVASCULAR ACCIDENT</u>						<u>10 MINUTES</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>						<u>10 YRS.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>STROKE 3 YRS AGO.</u>							
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>—</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1947</u> , to <u>28 DEC</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>20 DEC</u> , 19 <u>57</u> , and that death occurred at <u>10:45 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J.P. Adwell</u>				ADDRESS (Street, city, town, state) <u>M.D. 401 Franklin St. Bel Air, Md.</u>		DATE SIGNED <u>Dec 27</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Dec. 31, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Priscilla Fournel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph William Foster</u>		ADDRESS <u>West Broadway Bel Air, Maryland</u>	
DATE <u>12-30-57</u>							

CERTIFICATE OF DEATH

DATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. PLACE OF DEATH

7. TIME OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF DECEASED

12. SIGNATURE OF BURIAL OFFICIAL

13. SIGNATURE OF CHURCH OFFICIAL

14. SIGNATURE OF FUNERAL HOME

15. SIGNATURE OF CEMETERY

16. SIGNATURE OF OTHER

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BUREAU V. 2

JAN 3 1953

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13195

13211

CERTIFICATE OF DEATH

Reg. Dist. No. 18v

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Harford Co.	MARYLAND	STATE Maryland	COUNTY Harford
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fallston	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fallston	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) Leo BADIN LATHROUM		4. DATE OF DEATH (Month) (Day) (Year) Dec. 24 1957	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 1897
9. AGE last birthday 60 yrs.		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Druggist		10b. KIND OF BUSINESS OR INDUSTRY self	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Leo Jefferson Lathroum		14. MOTHER'S MAIDEN NAME Mary Odie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT & ADDRESS Mrs. Mary C. Lathroum		Fallston Md.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) Terminal Arrhythmia or Coronary Occlusion			15 min.
ANTECEDENT CAUSE(S) DUE TO (B) Chronic Congestive Heart Failure			2 yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerosis & Valvular Insufficiency and Cardiomegaly			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 1957 , to Dec. 1957 , that I last saw the deceased alive on Dec. 20, 1957 , and that death occurred at 1:55 P.M. from the causes and on the date stated above.			
SIGNATURE William A. Tye		DATE SIGNED 12-24-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem	
DATE THEREOF 12/27/57		LOCATION (City, town, of county) (State) Balto.	
25. REC'D BY REGISTRAR 12/27/57		26. REGISTRAR'S SIGNATURE WIEDEFELD & SON-Greenmount & 22nd	
27. REGISTRAR'S SIGNATURE WIEDEFELD & SON-Greenmount & 22nd		28. FUNERAL DIRECTOR'S SIGNATURE WIEDEFELD & SON-Greenmount & 22nd	
29. ADDRESS WIEDEFELD & SON-Greenmount & 22nd			

CERTIFICATE OF DEATH

Form 100-1

1. Name of deceased (Print or type)

2. Sex (M or F)
3. Date of birth (Month, day, year)
4. Place of birth (City, State, Country)
5. Usual residence (City, State, Country)
6. Cause of death (Print or type)

7. Date of death (Month, day, year)

8. Place of death (City, State, Country)

9. Signature of physician (Print or type)

10. Signature of registrar (Print or type)

11. Signature of informant (Print or type)

12. Signature of witness (Print or type)

13. Signature of witness (Print or type)

14. Signature of witness (Print or type)

15. Signature of witness (Print or type)

16. Signature of witness (Print or type)

17. Signature of witness (Print or type)

18. Signature of witness (Print or type)

19. Signature of witness (Print or type)

20. Signature of witness (Print or type)

21. Signature of witness (Print or type)

22. Signature of witness (Print or type)

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53. Signature of witness (Print or type)

54. Signature of witness (Print or type)

55. Signature of witness (Print or type)

56. Signature of witness (Print or type)

57. Signature of witness (Print or type)

58. Signature of witness (Print or type)

BUREAU K. R.

DEC 27 1957

RECEIVED

RECEIVED



13187 CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY <i>Harford</i> <i>Maryland</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>114 N. Union Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Rebecca Charora Keithiser</i>		4. DATE OF DEATH <i>12/23/57</i> 5-7 19	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/13/1879</i>
9. AGE (In years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Harford</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James W. Foster</i>		14. MOTHER'S MAIDEN NAME <i>Lama Jane Knight</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>R. H. Luthers</i> <i>114 N. Union Ave.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Myeloma</i> <i>199.8</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>working Colon Liver and Ovaries</i> DUE TO (c) <i>—</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 23, 1957</i> to <i>Dec 23, 1957</i> , that I last saw the deceased alive on <i>Dec 23, 1957</i> , and that death occurred at <i>8:45 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <i>12-26-57</i>	
ACTUAL SIGNATURE <i>A. L. Lewis M.D.</i> M.D. <i>Harford</i>		PHYSICIAN'S NAME (Type) <i>A. L. Lewis</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/26/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Harford</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James W. Foster</i> ADDRESS <i>Harford</i>		24a. REC'D BY REGISTRAR <i>12-26-57</i>	
24b. REGISTRAR'S SIGNATURE <i>A. L. Lewis M.D.</i>			

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of medical examiner		20. Signature of pathologist		21. Signature of toxicologist	
22. Signature of bacteriologist		23. Signature of virologist		24. Signature of epidemiologist	
25. Signature of public health nurse		26. Signature of health visitor		27. Signature of social worker	
28. Signature of psychologist		29. Signature of psychiatrist		30. Signature of sociologist	
31. Signature of anthropologist		32. Signature of linguist		33. Signature of geographer	
34. Signature of historian		35. Signature of archaeologist		36. Signature of paleontologist	
37. Signature of zoologist		38. Signature of botanist		39. Signature of geologist	
40. Signature of astronomer		41. Signature of meteorologist		42. Signature of climatologist	
43. Signature of oceanographer		44. Signature of hydrographer		45. Signature of cartographer	
46. Signature of geophysicist		47. Signature of geodesist		48. Signature of geomatics engineer	
49. Signature of geoscientist		50. Signature of geotechnical engineer		51. Signature of geological engineer	
52. Signature of geophysicist		53. Signature of geodesist		54. Signature of geomatics engineer	
55. Signature of geoscientist		56. Signature of geotechnical engineer		57. Signature of geological engineer	
58. Signature of geophysicist		59. Signature of geodesist		60. Signature of geomatics engineer	
61. Signature of geoscientist		62. Signature of geotechnical engineer		63. Signature of geological engineer	
64. Signature of geophysicist		65. Signature of geodesist		66. Signature of geomatics engineer	
67. Signature of geoscientist		68. Signature of geotechnical engineer		69. Signature of geological engineer	
70. Signature of geophysicist		71. Signature of geodesist		72. Signature of geomatics engineer	
73. Signature of geoscientist		74. Signature of geotechnical engineer		75. Signature of geological engineer	
76. Signature of geophysicist		77. Signature of geodesist		78. Signature of geomatics engineer	
79. Signature of geoscientist		80. Signature of geotechnical engineer		81. Signature of geological engineer	
82. Signature of geophysicist		83. Signature of geodesist		84. Signature of geomatics engineer	
85. Signature of geoscientist		86. Signature of geotechnical engineer		87. Signature of geological engineer	
88. Signature of geophysicist		89. Signature of geodesist		90. Signature of geomatics engineer	
91. Signature of geoscientist		92. Signature of geotechnical engineer		93. Signature of geological engineer	
94. Signature of geophysicist		95. Signature of geodesist		96. Signature of geomatics engineer	
97. Signature of geoscientist		98. Signature of geotechnical engineer		99. Signature of geological engineer	
100. Signature of geophysicist		101. Signature of geodesist		102. Signature of geomatics engineer	

RECEIVED
DEC 30 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13197
13212 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Abingdon</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Long Bar</u>		d. STREET ADDRESS <u>Long Bar</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Frank C. Lord</u> First Middle Last		4. DATE OF DEATH <u>December 24</u> 19 <u>57</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5, 1887</u>
9. AGE (in years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Munition Handler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.,</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.,</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-14-0968</u>	17. INFORMANT <u>Frederick J. Mover</u> Address <u>Abingdon, Maryland.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>12-24-57</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 26, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran</u>	22d. LOCATION (City, town, or county) (State) <u>Joppa, Harford, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McBrum</u> ADDRESS <u>Abingdon Maryland.</u>		24a. REC'D BY REGISTRAR <u>Dec. 26, 1957</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Norma G. Moore</u>

STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

JEC 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13198

13188

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Hartford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Hartford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>		c. LENGTH OF STAY IN 1b <i>approx 4 mths.</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>		32	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>277 Victory Lane</i>		d. STREET ADDRESS <i>277 Victory Lane</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Thomas Joseph Loughran</i>		4. DATE OF DEATH <i>12/19/57</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1/10/1906</i>	
9. AGE (In years last birthday) <i>51</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maintenance Supv.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hartford Schools</i>	
11. BIRTHPLACE (State or foreign country) <i>Peru</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frank Loughran</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ellen Merrick</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates of service) <i>WW II</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Wife - 277 Victory Lane Bel Air Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Atherosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 mths</i> <i>1 yr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug</i> , 19 <i>55</i> , to <i>Dec</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Dec 17</i> , 19 <i>57</i> , and that death occurred at <i>230 A</i> .M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>J. Ralph Horky</i> M.D.		<i>Churchville Md</i>	
PHYSICIAN'S NAME (Type) <i>J. Ralph Horky MD</i>		<i>Churchville Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/23/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Mary's</i>		22d. LOCATION (City, town, or county) (State) <i>Hanover Township, Peru</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Garrison</i>		ADDRESS <i>abernethy rd</i>	
24a. REC'D BY REGISTRAR <i>12/20/57</i>		24b. REGISTRAR'S SIGNATURE <i>Nellie R Perry</i>	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13189

CERTIFICATE OF DEATH

13199

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. LENGTH OF STAY IN 1b <u>1 Hour</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Herman Wilson</u> Middle <u>Minnick</u> Last <u>Minnick</u>				4. DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 18, 1905</u>	
9. AGE (In years last birthday) yrs. <u>52</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Aberdeen Proving Ground Government Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Roy A. Minnick</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Wilgis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-22-0961</u>		17. INFORMANT <u>Robert Minnick, Bel Air, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <u>Hypertensive Cardio-vascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <u>Forest Hill, Md.</u>		(County) _____ (State) _____	
21. I certify that I attended the deceased from <u>May 2</u> , 1937, to <u>December 4</u> , 1957, that I last saw the deceased alive on <u>December 4</u> , 1957, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Md.</u> <u>December 6, 1957</u> PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>DEC. 7, 1957 BURIAL</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>DEER CREEK Methodist Cent.</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>				ADDRESS <u>W. Broadway, Bel Air, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 12-6-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Priscilla Furwood</u>			

13190 CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hanford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x1 Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural #2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arvie</u> Middle <u>Everist</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>10th</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/6/1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Geo. E. Everist</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Aru Baker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>Mrs Geo R. Jones Aberdeen #2 Rd.</u>		Address <u>_____</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Liver</u> DUE TO (b) <u>156.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>_____</u>		INTERVAL BETWEEN ONSET AND DEATH <u>_____</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-3</u> , 19 <u>37</u> , to <u>12/10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-10-57</u> , and that death occurred at <u>3</u> A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Hanford, Md.</u> DATE SIGNED <u>12/11/57</u>	
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u>		PHYSICIAN'S NAME (Type) <u>A.L. Lewis</u> M.D. <u>Havre de Grace, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/12/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Smiths Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen #2 Rd.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Garring Aberdeen Rd.</u> ADDRESS <u>_____</u>		24a. REC'D BY REGISTRAR <u>11-57</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Form 10-57

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE			
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA		MOBILE		MOBILE		ALABAMA			
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
JANUARY 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		MEMPHIS		TENNESSEE		JANUARY 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		MEMPHIS		TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS		GRANDPARENTS	
SHOOTING		HOMICIDE		ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED		ONE		NONE		NONE		NONE	
DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH	
FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS		FINGERPRINTS	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE		SIGNATURE OF JUDGE	
SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK	

BUREAU V. S.

DEC 13 1957

RECEIVED

13191 CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u> 24			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>710 MARKET ST.</u>				d. STREET ADDRESS <u>710 MARKET ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>EVALEEN</u> Middle <u>MOORE</u> Last <u>MOORE</u>				4. DATE OF DEATH Month <u>December</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 9, 1865</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>N. J.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JAMES ALE</u>				14. MOTHER'S MAIDEN NAME <u>HANNAH WADDINGTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MRS. JENNIE F. HIPPLE, HAVRE DE GRACE, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS - CONGESTIVE H. D.</u> DUE TO (c) <u>OLD AGE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>—</u> p. <u>—</u> m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Oct.</u> , 19 <u>57</u> , to <u>DEC 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 15</u> , 19 <u>57</u> , and that death occurred at <u>11:15 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Cunther D. Hirsch</u> M.D.				ADDRESS (Street, city or town, state) <u>421 CONGRESS AVE. HAVRE DE GRACE, MD.</u>			
DATE SIGNED <u>12-20-57</u>							
PHYSICIAN'S NAME (Type) <u>CUNTER D. HIRSCH</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-20-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL</u>		22d. LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>				ADDRESS <u>HAVRE DE GRACE MD</u>		24a. REC'D BY REGISTRAR <u>DATE 12-20-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis m.d.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 23 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13213

CERTIFICATE OF DEATH

13202

Reg. Dist. No. 151

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ROBAL HAVRE DE GRACE</u>		LENGTH OF STAY (in this place) <u>3 WEEKS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ROBAL HAVRE DE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>LILLIE MAY MORRIS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC 12 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAY 7, 1894</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Thomas CURRY</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN A. MOBERRY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>WILLIAM R MORRIS</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.0 IMMEDIATE CAUSE (A) <u>Intens acute heart Disease</u></u>						<u>6 months</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>DEC 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>mt 30</u> , 19 <u>57</u> , and that death occurred at <u>5 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Wm H. Wademan</u> M.D.				ADDRESS (Street, city, town, state) <u>Havre de Grace MD</u>		DATE SIGNED <u>12/14/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>12-15-1957</u>	NAME OF CEMETERY OR CREMATORY <u>Rock Run CEMI.</u>		LOCATION (City, town, or county) <u>HARFORD Co.</u>		(State) <u>MD</u>	
24. REC'D BY REGISTRAR DATE <u>Dec. 17/57</u>	REGISTRAR'S SIGNATURE <u>Lillie R. Perry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>Havre de Grace MD</u>		

CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BIRTH

EDUCATIONAL DERIVATION

INDUSTRY OR OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATIONAL DERIVATION

INDUSTRY OR OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATIONAL DERIVATION

INDUSTRY OR OCCUPATION

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INDUSTRY OR OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATIONAL DERIVATION

INDUSTRY OR OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATIONAL DERIVATION

INDUSTRY OR OCCUPATION

BUREAU V. S.

DEC 20 1957

RECEIVED

SHORT FORM

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13192 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13203

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>	
c. LENGTH OF STAY in 1b <u>DOA</u>		d. STREET ADDRESS <u>1 Baldwin Manor B-6-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in-hospital, give street address) <u>Harford Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nancy Mac Morris</u>		4. DATE OF DEATH <u>December 7 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5 Sept. 1939</u>
9. AGE (In years last birthday) <u>18</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bata Shoe Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Penna.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Howard Morris</u>	
14. MOTHER'S MAIDEN NAME <u>Amy Deckman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>213-36-9898</u>		17. INFORMANT <u>Howard Morris, Baldwin Manor, Aberdeen Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G.S.W. R chest</u> <u>919.6</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Man dropped pistol from belt + it fired</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> am. <u>Dec 7</u> 19 <u>57</u> p. m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Shamrock Drive Aberdeen Harford</u>	20f. (City or town) (County) (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Beltin, Md</u> DATE SIGNED <u>12-8-57</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/11/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Southern Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Dublin, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Larring</u>		ADDRESS <u>Aberdeen, Md.</u>	24a. REC'D BY REGISTRAR <u>Dec 9-57</u> 24b. REGISTRAR'S SIGNATURE <u>Nellie R. Perry</u> <u>Dr. A. L. Lewis</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED - NAME & RESIDENCE

John Doe

John Doe

John Doe

John Doe

No.

John Doe

BUREAU V. S.

DEC 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13193

CERTIFICATE OF DEATH

13204

Reg. Dist. No.

182

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Bond Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle C Last Orsborn		4. DATE OF DEATH Month December 18 Year 19 57	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 7, 1874
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY House Work	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Enos Rice		14. MOTHER'S MAIDEN NAME Alice Chancey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hannah Toney, Bel Air, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Uremia 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Glomerular Nephritis with Hypertension DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 Months 10 Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1947 , 19____, to December 18, 1957 , that I last saw the deceased alive on December 18, 1957 , and that death occurred at 10:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Willard P. Hudson M.D.		ADDRESS (Street, city or town, state) Forest Hill, Maryland DATE SIGNED DECEMBER 19, 1957	
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 21, 1957	
22c. NAME OF CEMETERY OR CREMATORY Hendon's Hill		22d. LOCATION (City, town, or county) (State) Bel Air R.D. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster Bel Air, Maryland		24a. REC'D BY REGISTRAR DATE 12-19-57	
24b. REGISTRAR'S SIGNATURE Miscella Snow			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. Name of deceased: John Doe
2. Sex: Male
3. Age: 45
4. Date of birth: Jan 15, 1912
5. Place of birth: St. Louis, Mo.
6. Usual residence: 123 Main St., Baltimore, Md.
7. Cause of death: Myocardial infarction
8. Date of death: Dec 20, 1957
9. Place of death: Home
10. Signature of attending physician: [Signature]
11. Signature of medical examiner: [Signature]
12. Signature of registrar: [Signature]

BUREAU V. S.

DEC 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13214

CERTIFICATE OF DEATH

13205

Reg. Dist. No. 150

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reckord Rd.				d. STREET ADDRESS Record Rd.			
3. NAME OF DECEASED (Type or print) First MARY Middle A. Last RUPPERT				4. DATE OF DEATH Month December Day 18 Year 19 57.			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1890	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At Home.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Kolb				14. MOTHER'S MAIDEN NAME Margaret Eisenreich.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Howard Ruppert		Address Same.	
18. CAUSE OF DEATH [Enter only one cause or line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO CONGESTIVE HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arteriosclerotic Heart Disease with decompensation. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 4 Mos. 7 yts.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/5 19 57 to 12/18 19 57 , that I last saw the deceased alive on 12/18 19 57 , and that death occurred at 11:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fork, Md. DATE SIGNED ACTUAL SIGNATURE Clifford F. Hudson M.D. PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON FORK, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-21-57.		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer CEM.		22d. LOCATION (City, town, or county) (State) 4430 BELAIR RD. BALTO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Geiler ADDRESS 9015 CONKLING ST. BALTO., MD.				24a. REC'D BY REGISTRAR DEC 23 1957		24b. REGISTRAR'S SIGNATURE Norma Moore	

CERTIFICATE OF DEATH

BUREAU V. S.

23 1957

RECEIVED

CLIFFORD F. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13215 CERTIFICATE OF DEATH

13206

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>no Street Rd.</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>Isaac</u> Middle <u>Slade</u> Last				4. DATE OF DEATH <u>Dec 20</u> - <u>1957</u> Month <u>Dec</u> Day <u>20</u> Year <u>1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 22 1890</u> 77 yrs.			
9. AGE (In years last birthday) <u>77</u>		10. UNDER 1 YEAR <u>28</u> Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Federal Hill</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General Farm</u>					
13. FATHER'S NAME <u>Wm Ralph Slade</u>				14. MOTHER'S MAIDEN NAME <u>Mary Susan Fletcher</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>David S. Slade</u> Address <u>Street Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis, generalized</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastro-enteritis & Colitis</u>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21. I certify that I attended the deceased from <u>Mar</u> , 1957, to <u>20 Dec</u> , 1957, that I last saw the deceased alive on <u>19 Dec</u> , 1957, and that death occurred at <u>1 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Tarrettsville, Md.</u> DATE SIGNED <u>Thos. A.E. Moseley, Jr.</u>									
ACTUAL SIGNATURE <u>Thos. A.E. Moseley, Jr.</u>				M.D. <u>Tarrettsville, Md.</u>					
PHYSICIAN'S NAME (Type) <u>Thos. A.E. MOSELEY, JR.</u>				<u>Tarrettsville, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Dec 22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tarrettsville</u>		22d. LOCATION (City, town, or county) (State) <u>Tarrettsville Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. E. Slade</u>				ADDRESS <u>Tarrettsville</u>		24a. REC'D BY REGISTRAR <u>2-23-57</u>			
						24b. REGISTRAR'S SIGNATURE <u>Lucille Lowwood</u>			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13194

CERTIFICATE OF DEATH

13207
Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harre-de-Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MYRTLE VIOLA SMITH</u>		4. DATE OF DEATH <u>12 27 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/4/1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>
13. FATHER'S NAME <u>Arthur A. Preston</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Howard Smith</u>		Address <u>607 Bourbon St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive G.I. Hemorrhage</u> <u>540.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Erosion of paracervical duct and cervix</u> DUE TO (c) <u>Acute ulceration</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 4, 1957</u> to <u>Dec 27, 1957</u> , that I last saw the deceased alive on <u>Dec 27, 1957</u> , and that death occurred at <u>8:45 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm K Brindle</u>		ADDRESS (Street, city or town, state) <u>Harre de Grace</u>	
PHYSICIAN'S NAME (Type) <u>Wm K. Brindle</u>		DATE SIGNED <u>12-28-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/30/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL</u>	22d. LOCATION (City, town, or county) (State) <u>HARREDEGRACE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington + Son, Harre de Grace, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 12-31-57</u>	24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>

RECEIVED

CERTIFICATE OF DEATH

13208

Reg. Dist. No.

Item #3. Film GH153185 1/269 km

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If no institution: Residence before admission) a. STATE MD. b. COUNTY XXXXXX ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harre-de-Grace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		d. STREET ADDRESS 317 Macon Street	
3. NAME OF DECEASED (Type or print) Katherine First Ann Middle GIRL Spellman Last		4. DATE OF DEATH Month 12 Day 27 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-26-57
9. AGE (In years last birthday) yrs. 17		IF UNDER 1 YEAR Months 17 Days 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) New born.		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME MARTIN Spellman JR.		14. MOTHER'S MAIDEN NAME Emiley Bernad y ne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature baby - Coliformy At. bacteria 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 12-26 , 19 57 , to 12-27 , 19 57 , that I last saw the deceased alive on 12-27 , 19 57 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE G. H. Richards Jr. M.D.		DATE SIGNED 12/28/57	
PHYSICIAN'S NAME (Type) G. H. Richards Jr.		Port de Posit - Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		12/28/57	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
St. Ann		Harford County, Md	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
James H. On Harford County, Md		DATE 12-28-57	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
		G. L. Lewis Jr.	

After death: Page 4

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

10

BUREAU V. E.

DEC 30 1957

RECEIVED

13196

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 401-A Watervliet Street		d. STREET ADDRESS 401-A Watervliet Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Susannah Dunsworth Taylor		4. DATE OF DEATH December 12 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Jan. 1876
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Boring	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. -- -- --		17. INFORMANT Olin O. Taylor Address Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Arterio Sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 10, 1957 , to Dec 12, 1957 , that I last saw the deceased alive on Dec 12, 1957 , and that death occurred at 2:30 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Andre Weiss MD		ADDRESS (Street, city or town, state) 17 North. Picher Bld DATE SIGNED 12/13/57	
PHYSICIAN'S NAME (Type) ANDRE WEISS MD		Aberdeen Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 12/14/57	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Hannibal Missouri
23. FUNERAL DIRECTOR'S SIGNATURE John G. Serruig ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR Dec. 14-57	24b. REGISTRAR'S SIGNATURE Willie R. Perry

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED <i>William Fortin</i>		DATE OF DEATH <i>Dec 12 1957</i>	
AGE <i>38</i>		SEX <i>Male</i>	
RACE <i>White</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Unknown</i>		CAUSE OF DEATH <i>Heart Disease</i>	
PLACE OF DEATH <i>Home</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>John D. Taylor</i>		SIGNATURE OF REGISTRAR <i>John D. Taylor</i>	
DATE OF SIGNATURE <i>Dec 12 1957</i>		DATE OF SIGNATURE <i>Dec 12 1957</i>	
LOCAL HEALTH OFFICE <i>Baltimore</i>		STATE HEALTH OFFICE <i>Baltimore</i>	
COUNTY <i>Baltimore</i>		STATE <i>Maryland</i>	

BUREAU V. 8

DEC 17 1957

RECEIVED

13197

CERTIFICATE OF DEATH

13210

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. LENGTH OF STAY IN 1b 17 DAYS			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE 24				d. STREET ADDRESS 214 S. Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET Vinson TRONE				4. DATE OF DEATH Month Day Year DECEMBER 19 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/7/1926	
9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWT.		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John D. Vinson				14. MOTHER'S MAIDEN NAME Willard Baker Logan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Dr. J. L. Lane Jr. 214 S. Washington Dr			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute lymphocytic leukemia 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4 months DUE TO (c) —				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 16th, 1957 to Dec 19th, 1957 , that I last saw the deceased alive on Dec 19th, 1957 , and that death occurred at 4:25 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward C. Loo, M.D.				ADDRESS (Street, city or town, state) 211 N. Union Ave. Haure de Grace, Md.			
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.				DATE SIGNED 12/19/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/21/57		22c. NAME OF CEMETERY OR CREMATORY Bellevue Memorial		22d. LOCATION (City, town, or county) (State) Bellevue, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Emmylou Pm. Harrell, Md.				ADDRESS Harrell, Md.			
24a. REC'D BY REGISTRAR DATE 12-21-57		24b. REGISTRAR'S SIGNATURE G. L. Hewitt M.D.					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Pages 2 and 3 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13216

CERTIFICATE OF DEATH

13211

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Walton			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DeFuniak Springs 48X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital, APG, Md.				d. STREET ADDRESS 304 S. 2nd Street			
3. NAME OF DECEASED (Type or print) First KENNETH Middle DEAN Last WHITTON				4. DATE OF DEATH Month December Day 7 Year 19 57			
5. SEX M	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 October 1955		9. AGE (In years last birthday) 2 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME Charlie M. Whitton				14. MOTHER'S MAIDEN NAME Helen Annett Ruryk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -- -- --		17. INFORMANT Father		Address 17 Fern Street Edgewood, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacterial meningitis, pneumococcic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 6 December, 1957 , to 7 December, 1957 , that I last saw the deceased alive on 7 December, 1957 , and that death occurred at 1:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE William M. Michener M.D.				ADDRESS USAH, APG, Md. DATE SIGNED 9 December 1957			
PHYSICIAN'S NAME (Type) WILLIAM M. MICHERNER, Capt, MC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/10/57		22c. NAME OF CEMETERY OR CREMATORY Magnolia Cemetery		22d. LOCATION (City, town, or county) (State) DeFuniak Springs, Fla.	
23. FUNERAL DIRECTOR'S SIGNATURE John S. Loring				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR Dec. 10/57	
				24b. REGISTRAR'S SIGNATURE Thelma R. Perry			

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Signature of physician		9. Signature of registrar	
JAMES H. HARRIS		Male		White		1890		1940		Baltimore, Md.		Heart disease		J. H. Harris		J. H. Harris	
10. Occupation		11. Marital status		12. Education		13. Religion		14. Usual residence		15. Usual occupation		16. Usual place of birth		17. Usual date of birth		18. Usual date of death	
None		Married		High School		Catholic		Baltimore, Md.		None		Baltimore, Md.		1890		1940	
19. Name of informant		20. Relationship		21. Signature of informant		22. Signature of registrar		23. Date of registration		24. Place of registration		25. Name of registrar		26. Signature of registrar		27. Date of registration	
J. H. Harris		Wife		J. H. Harris		J. H. Harris		1940		Baltimore, Md.		J. H. Harris		J. H. Harris		1940	

RECEIVED
DEC 12 1940
BUREAU

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13198

CERTIFICATE OF DEATH

13212

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		LENGTH OF STAY (in this place) <u>6 MOS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>			
TOWN <u>HAVRE DE GRACE</u>				TOWN <u>HAVRE DE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>200 So. UNION AVE.</u>				STREET ADDRESS (If rural give location) <u>200 So. UNION AVE.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>CHARLES MAURICE WOLBERT MD.</u>				(Month) (Day) (Year) <u>DEC. 3 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JUNE 11, 1898</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MEDICAL DOCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK MAURICE WOLBERT</u>				14. MOTHER'S MAIDEN NAME <u>CAROLYN C. BURLINGHAM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WORLD WAR #II</u>		17. INFORMANT & ADDRESS <u>DR. FRANK WOLBERT</u> <u>HAVRE DE GRACE MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
463X IMMEDIATE CAUSE (A) <u>Acute Pulmonary Embolism</u>						<u>15 min</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Phlebotrombosis R. leg</u>						<u>13 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Malignancy of large intestine</u>						<u>1 yr</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1, 1957</u> , to <u>3 Dec. 1957</u> , that I last saw the deceased alive on <u>Dec. 3, 1957</u> , and that death occurred at <u>330 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wallace H. Sadowsky</u> M.D.				ADDRESS (Street, city, town, state) <u>600 S. Union Ave. Havre de Grace, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>DEC. 5, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>		LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD.</u>	
24. REC'D BY REGISTRAR DATE <u>12-5-57</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>Havre de Grace, Md.</u>	

CERTIFICATE OF DEATH

13198

PLACE ON FILE IN

DEPARTMENT

OF HEALTH

AND

WELFARE

OF THE STATE

OF MARYLAND

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF INTERVIEW

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF CLERK

NAME OF ASSISTANT

NAME OF ATTORNEY

NAME OF JUDGE

NAME OF SHERIFF

NAME OF CONSTABLE

NAME OF DEPUTY

NAME OF CLERK

NAME OF ASSISTANT

NAME OF ATTORNEY

NAME OF JUDGE

NAME OF SHERIFF

NAME OF CONSTABLE

BUREAU V. S.

DEC 6 1957

RECEIVED

21077457200

CERTIFICATE OF DEATH

Reg. Dist. No.

13213

181

1. PLACE OF DEATH o. COUNTY USAH APG, HARDFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HARDFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ABERDEEN PROVING GROUNDS				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAH APG, MD.				e. STREET ADDRESS 18 LIBERTY ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WANE Middle NMI Last WONG				4. DATE OF DEATH Month DEC Day 28 Year 1957			
5. SEX MALE	6. COLOR OR RACE 1/4 Mong.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 DEC 50 (56)	9. AGE (In years last birthday) 1 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) ABERDEEN MARYLAND		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME WOTIM WONG				14. MOTHER'S MAIDEN NAME DOMIANA BAROY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Wotim Wong		Address 18 Liberty St. Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DEHYDRATION, ACUTE 571.0 DUE TO VOMITING AND DIARRHEA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHOPNEUMONIA DUE TO (c) BRONCHOPNEUMONIA						INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 3 DAYS 2 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 Dec , 19 57 , to 28 Dec , 19 57 , that I last saw the deceased alive on 28 Dec , 19 57 , and that death occurred at 1 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 303 D Augusta St. Aberdeen, Md. DATE SIGNED 28 Dec 57							
ACTUAL SIGNATURE Charles C. Weise M.D.				PHYSICIAN'S NAME (Type) CHARLES C. WEISE, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/31/57		22c. NAME OF CEMETERY OR CREMATORY Nat. Mem. Cem. of Pacific Honolulu, Hawaii		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR Dec 31-57 24b. REGISTRAR'S SIGNATURE Mellie R. Perry	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

13199

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G223 12-26-57 et

13214

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY Neark	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace	c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Neark 46 X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS 12 Park Lane	
3. NAME OF DECEASED (Type or print) William T. Wright		4. DATE OF DEATH December 15 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Approx. 35 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Service Station	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME William Thomas Wright		14. MOTHER'S MAIDEN NAME Adele Walstrom	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hematoma 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident 20c. TIME OF INJURY Month, Day, Year Hour a. m. 12-13-57 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, or other public bldg., etc.) Cherry Hill 20f. (City or town) Cherry Hill (County) Cecil (State) Md. 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Gerald C Palmer M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md. DATE SIGNED 12-16-57 EXAMINER'S NAME (Type) Gerald C. Palmer M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12-19-1957 22c. NAME OF CEMETERY OR CREMATORY Silverbrook 22d. LOCATION (City, town, or county) (State) Wilmington Delaware 23. FUNERAL DIRECTOR'S SIGNATURE Nicholas J. Corleto Wilm., Dela 24a. REC'D BY REGISTRAR DEC 19 1957 24b. REGISTRAR'S SIGNATURE Dr. P. L. Lewis			

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. E.

DEC 19 1957

RECEIVED